SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM ACTIVE NOTICE OF ELECTION (NOE)
PERMANENT PART-TIME TEACHER

P
SEE INSTRUCTIONS IF COMPLETING BY HAND USE BLACK INK

ACTION

Check One:
☐ New Hire
☐ Transfer
☐ Change

☐ Address Change_____
☐ Other *(Specify)* _____
Date of Occurrence _____
SSN Change - Incorrect # _____
(Attach Copy of Social Security Card)
Name Change - Prior Name _____

BA Use Only
Effective Date: _____
Group ID#: _____
Group Name: _____

MoneyPlu$
☐ Yes ☐ No

Health Savings Account
☐ Yes ☐ No
(For Use With Savings Plan)

ENROLLEE INFO

1. Social Security Number	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM/DD/YYYY
___-___-___					

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	( )	( )	

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code Select	18. Annual Salary	19. Date of Hire MM/DD/YYYY

COVERAGE

It is your responsibility to select the appropriate insurance coverage(s). See the instructions before making your choice(s). Alterations in this section are not allowed.

20. CATEGORY *(Select based on the number of hrs.)*
☐ I. 15-19 hours
☐ II. 20-24 hours
☐ III. 25-29 hours

21. HEALTH PLAN *(Basic Life/Basic LTD not provided with health coverage)*
*(Refuse or select **one** plan and **one** category)*

PLAN
☐ Refuse
☐ Standard
☐ HMO_____ *Name of HMO*
☐ Savings (Non-Medicare)

CATEGORY *(Select One)*
☐ Enrollee
☐ Enrollee/Child(ren)
☐ Enrollee/Spouse ☐ Family

22. STATE DENTAL PLAN *(Select One)*
☐ Refuse ☐ Family
☐ Enrollee
☐ Enrollee/Spouse
☐ Enrollee/Child(ren)

23. DENTAL PLUS *(Select One)*
☐ Refuse
☐ Yes

MEDICARE AND OTHER COVERAGE

LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR PART B OF MEDICARE.

24. NAME	MEDICARE#	ELIGIBLE DUE TO	EFFECTIVE DATE PART A MM/DD/YYYY	EFFECTIVE DATE PART B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

Do you or any of your dependents have other group health coverage? ☐YES ☐NO Does this coverage include pharmacy benefits? ☐YES ☐NO
If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing conditions, if applicable.

25. DEPENDENT NAME	INSURANCE COMPANY	POLICY HOLDER DATE OF BIRTH	EFFECTIVE DATE OF POLICY	TERMINATION DATE (If Applicable)

DEPENDENTS

List spouse and eligible children to be covered under health and/or dental. If they are not listed, they will not be covered.
Is your spouse a state employee or retiree? ☐YES ☐NO

Add (A) or Delete (D)	26. Dependent SSN#	Last Name	First Name	SEX M/F	Relationship	Date of Birth MM/DD/YYYY	Complete Below If Child is Over 19
	Spouse						Spouse employed by state-covered entity? ☐Yes ☐No
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated

CERTIFICATION & AUTHORIZATION

27. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period (every two years). Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period (every two years) unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan.
AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.
DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature _____ Date _____

28. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Date _____

EMPLOYEE INSURANCE PROGRAM
INSTRUCTIONS FOR ACTIVE NOTICE OF ELECTION
PERMANENT PART-TIME TEACHER

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ACTION: Indicate type of action to be taken. MONEYPLU$: Premiums for health, dental and MONEYPLU$ Accounts are deducted on a pretax basis. There is an administrative fee for the pretax deductions. MoneyPlu$ changes are limited by IRS restrictions and must be made during enrollment or within 31 days of the date of occurrence of a qualifying change in family status. HEALTH SAVINGS ACCOUNT: To be used with Savings Plan and is governed by IRS.

ENROLLEE INFORMATION: Blocks 1-19 must be completed for all transactions, including a refusal.

LIST OF COUNTY CODES:

01 Abbeville	11 Cherokee	21 Florence	31 Lee	41 Saluda
02 Aiken	12 Chester	22 Georgetown	32 Lexington	42 Spartanburg
03 Allendale	13 Chesterfield	23 Greenville	33 McCormick	43 Sumter
04 Anderson	14 Clarendon	24 Greenwood	34 Marion	44 Union
05 Bamberg	15 Colleton	25 Hampton	35 Marlboro	45 Williamsburg
06 Barnwell	16 Darlington	26 Horry	36 Newberry	46 York
07 Beaufort	17 Dillon	27 Jasper	37 Oconee	99 Out of S.C.
08 Berkeley	18 Dorchester	28 Kershaw	38 Orangeburg	
09 Calhoun	19 Edgefield	29 Lancaster	39 Pickens	
10 Charleston	20 Fairfield	30 Laurens	40 Richland	

COVERAGE: Alterations in this section are not allowed.

Block 20. Select a category based on number of hours worked.

Block 21. HEALTH: Before making a health plan selection, refer to the plan descriptions provided by your employer. To decline health coverage, check “Refuse.” If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can apply for coverage for yourself and/or your dependent(s) only during an open enrollment period (every two years) or within 31 days of a special eligibility situation. BASIC LIFE AND BASIC LTD: Not provided with health coverage. To select a health plan, check only one block. To select a category, check only one block. For dependent(s) to be covered, they must be listed in **Block 26**, and the appropriate category must be selected.

Block 22. DENTAL: To decline dental coverage, check “Refuse.” If you refuse dental now, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period (every two years). To select coverage, check only one block. For dependents to be covered, they must be listed in **Block 26**, and the appropriate category must be selected.

Block 23. DENTAL PLUS: To select Dental Plus coverage, check “Yes.” To refuse coverage, select “Refuse.” You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

MEDICARE AND OTHER COVERAGE:
Block 24. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and /or Part B of Medicare.

Block 25: If you checked “Yes,” list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check “No” and list the termination date of the policy.

DEPENDENT INFORMATION: Block 26. If you select a category with spouse/dependent child(ren), they must be listed to be covered. A spouse can only be covered as a dependent if not a state employee. A state employee is defined as an employee of a state agency, public school district, county, municipality, local subdivision or other entity participating in the State of South Carolina Insurance Benefits Program. If spouse is a state employee or is employed at a state-covered entity, check “Yes.” Legal documentation is required for all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister, adopted child). For a child age 19 through 24 to be considered eligible for coverage, the dependent must be a full-time student or incapacitated. (Documentation required for both.) Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION:

Block 27: Form must be signed and dated by employee within 31 days of hire or the qualifying event.

Block 28: Benefits Administrator must sign and date form before submitting it to the Employee Insurance Program.

BENEFITS ADMINISTRATOR SHOULD MAIL ORIGINAL COMPLETED FORM AND ALL DOCUMENTATION TO:
Employee Insurance Program, Operations, P.O. Box 11661, Columbia, SC 29211.